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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

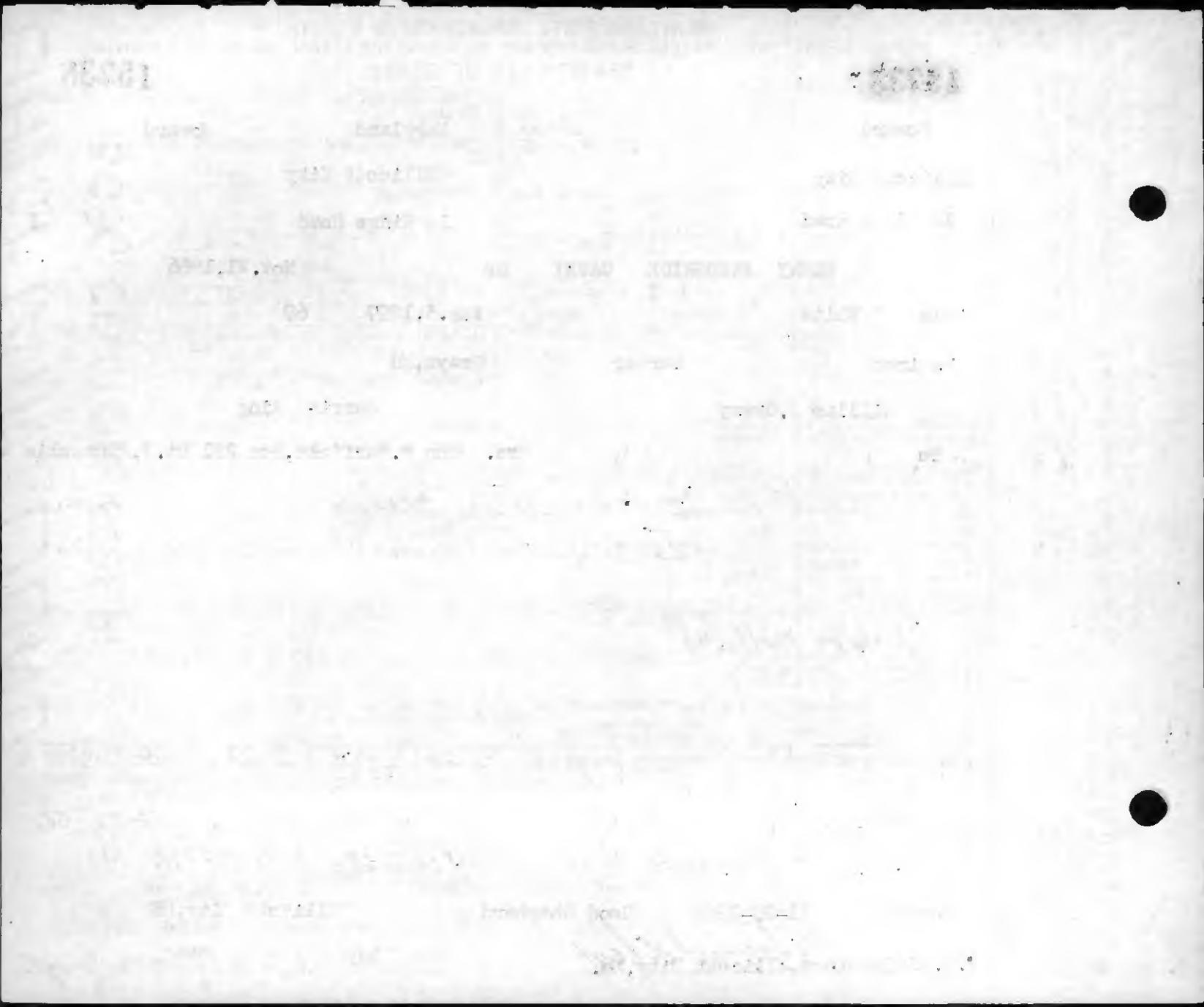
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15738 15738

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 Ellicott City		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 Ridge Road		d. STREET ADDRESS 14 Ridge Road	
3. NAME OF DECEASED (Type or print) HARRY FREDERICK CAVEY Sr		First Middle Last	4. DATE OF DEATH Nov. 21, 1966
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Barber	11. BIRTHPLACE (County & State, or foreign country) Grays, Md
13. FATHER'S NAME William J. Cavey		14. MOTHER'S MAIDEN NAME Carrie King	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. John W. Warfield, Box 281 Rt. 5, Annapolis
Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Coronary artery occlusion arteriosclerotic Cardio-vascular disease INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus		5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		2dd. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	2de. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on _____, and that death occurred at _____ A.M., from the causes and on the date stated above.		22b. DATE SIGNED 11-22-66	
22a. SIGNATURE Thomas F. Herbert, M.D.		22d. ADDRESS 44 Church Rd, Ellicott City, Md.	
22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 11-23-1966		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd	
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS 9 Ridge Road, Ellicott City, Md.		DATE NOV 23 1966	



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**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

15736**CERTIFICATE OF DEATH****15739**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b 4 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Meadowridge Ave.		e. STREET ADDRESS Meadowridge Ave.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LILLIAN	Middle BELLE	Last DAVIS
4. DATE OF DEATH Month Day Year	Nov. 21, 1966 19		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec/ 16/ 1885
9. AGE (In years) IF UNOER 1 YEAR last birthday 80 yrs.	10. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Belair- Ohio	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Perry E. Lovejoy		14. MOTHER'S MAIDEN NAME Mary Elizabeth Main	
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT James L. Davis- Meadowridge Ave.-Elkridge-	Address Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH Cardio-vascular disease 2 yrs deformities of age 54 yrs Senile Dementia 6 mo			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1964 to Nov 20, 1966 , that (II) (we) last saw the deceased alive on Nov 20, 1966 , and that death occurred at Elkridge M, from the causes and on the date stated above.			
22a. SIGNATURE B.B. Brumbaugh		22b. DATE SIGNED 11/21/66	
22c. PHYSICIAN'S NAME (Type) B.B. Brumbaugh	ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>	ME. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS 5609 Main St Elkridge Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 23-1966	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR Elwood T. M.R. Etchison & Son	ADDRESS Whitmore Frederick, Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
		DATE NOV 22 1966	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15737

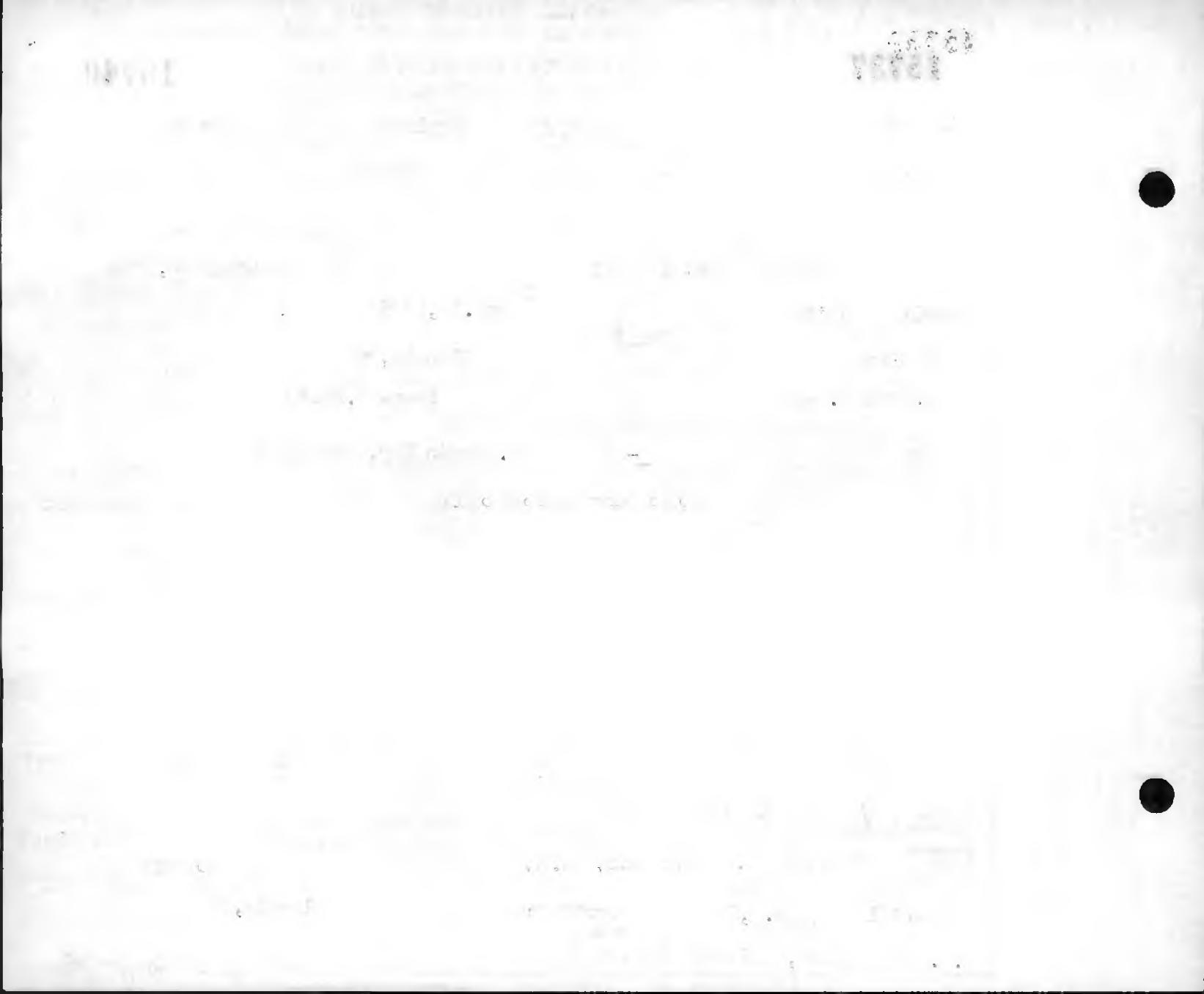
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15740

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit slip. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenelg		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNIE MERCER DAY		First	Middle
4. DATE OF DEATH November 28, 1966		Last	Month Day Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8. DATE OF BIRTH Feb. 10, 1885	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Glenelg, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joshua B. Day		14. MOTHER'S MAIDEN NAME Laura V. Hobbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mr. Marvin Day, Glenelg, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH Instant	
4201 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Whitaker</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Howard	
EXAMINER'S NAME (Type) Charles S. Whitaker, M.D.		22. DATE SIGNED 11/29/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 1, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Providence
23d. LOCATION (City or Town) Glenelg, Md		(County) (State)	
24. FUNERAL DIRECTOR <i>R. Higinbotham</i> F.C. Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR NOV 30 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

15738

15741

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS Pine Orchard-Ellicott City		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Orchard-Ellicott City				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Lillie May Dosh		First	Middle	Last	4. DATE OF DEATH Nov. 19	Month	Day	Year 1966
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1887		9. AGE (In years last birthday) yrs. 79	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Late-Samuel Hyde		14. MOTHER'S MAIDEN NAME Late-Diehlman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Mr. Wilbur H. Dosh Pine Orchard - Ellicott City, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular occlusion</i>		DUE TO (b) <i>Arteriosclerotic cardio-vascular disease</i>		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 min		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4021</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 7-21 , 19 59 , to 11-19 , 19 66 , that I last saw the deceased alive on 11-17 , 19 66 , and that death occurred 6:30 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. 44 Church Rd, Ellicott City, Md.		DATE SIGNED 11-19-66		
ACTUAL SIGNATURE <i>Thomas F. Herbert</i>								
PHYSICIAN'S NAME (Type) Thomas F. Herbert				Church Rd.-Ellicott City, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-66		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cem.		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.-4101 Edmondson Ave.		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 22, 1966		24b. REGISTRAR'S SIGNATURE <i>Charles J. Geiger</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

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15739

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15742

1. PLACE OF DEATH O. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) O. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lisbon		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 40		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM A. FUNDERBURK		4. DATE OF DEATH Month November	Day Year 3 19 66
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		9. AGE (In years last birthday) 51 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY State of Maryland		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME William E. Funderburk		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Doris F. Funderburk, 328 King George Dr		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Traumatic Injuries. 8234 DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Acute Ethylism.			
20e. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto which ran off roadway.	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> p.m. 11/3 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street
20f. (City or town) Lisbon		(County) Howard (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Petty</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		Address (Street, city, town, or county) Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-7-66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Dorchester Memorial Park
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue, 21229		25a. REC'D BY REGISTRAR NOV 7 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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FOR STATE
HEALTH DEPT.

1 MARYLAND
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
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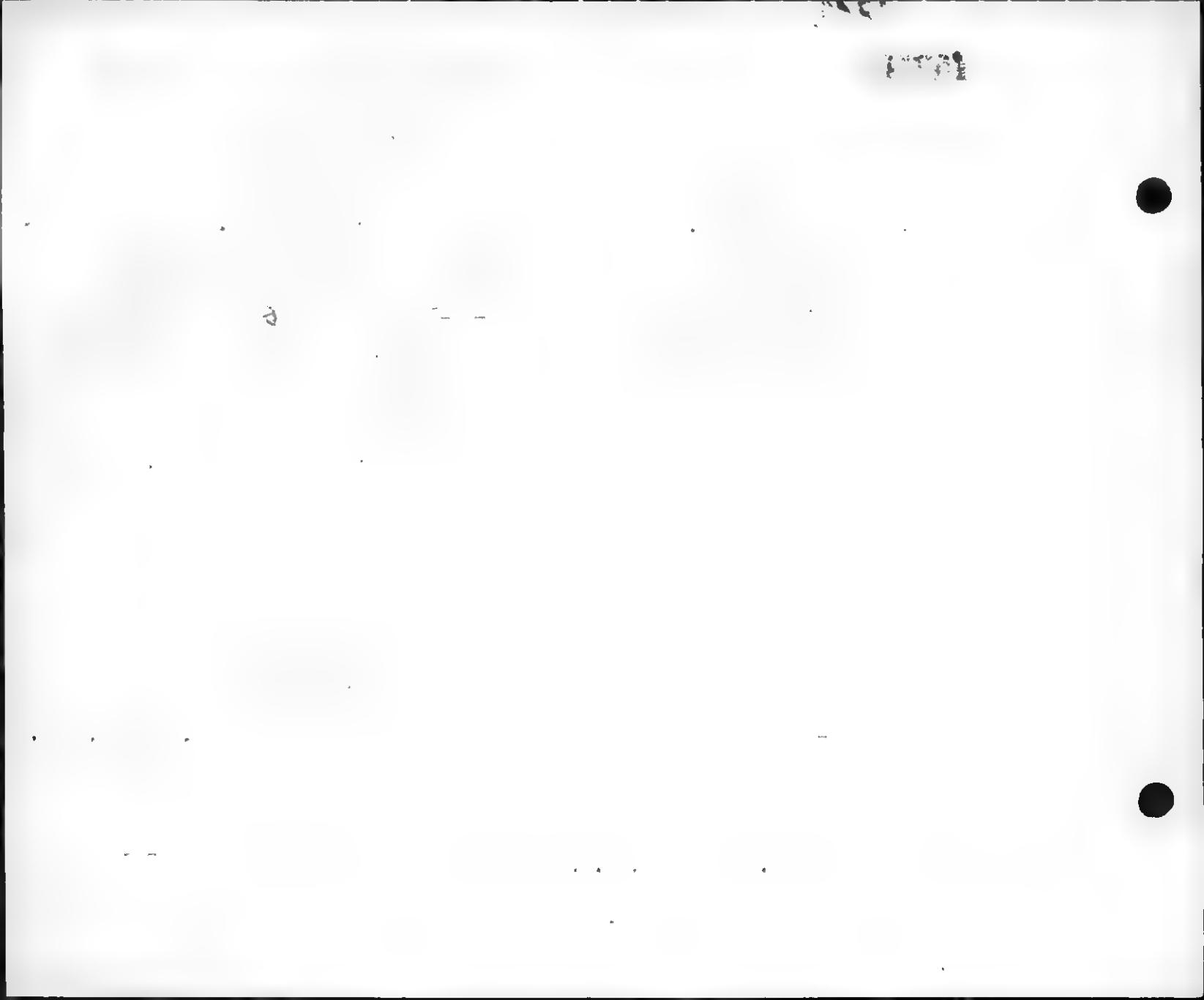
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15743

PLACE OF DEATH a. COUNTY Howard			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Ellicott City			c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Ellicott City		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 121 Turf Valley Rd.			d. STREET ADDRESS 121 Turf Valley Rd.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print)		First PRISCILLA	Middle HART	Last GERNON	4 DATE OF DEATH Month November Day 5 Year 1966
S SEX Female	6 COLOR OR RACE White	7 MARRIED W.DOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 9-19-1920	9 AGE (In years lost birthday) yrs 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Fall River, Mass	
13. FATHER'S NAME Gardiner Hart		14. MOTHER'S MAIDEN NAME Edith Coolridge			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Frank Gernon, 121 Turf Valley Rd. Ellicott	
Address City					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia due to carbon monoxide INTERVAL BETWEEN ONSET AND DEATH 101					
DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) slowing the underlying cause last (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Asphyxia by carbon monoxide from car exhaust			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 2 p.m. 11-5 1966		20d. INJURY OCCURRED at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Garage or home	20f. (City or town) Ellicott City, Howard, Md.	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Charles S. Springate, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-8-1966	23c. NAME OF CEMETERY OR CREMATORY St. Johns	23d. LOCATION (City or Town) (County) (State) Ellicott City, Md	
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR DATE NOV 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15741

CERTIFICATE OF DEATH

15744

1. PLACE OF DEATH a. COUNTY Howard MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville c. LENGTH OF STAY IN 1D Years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 32			d. STREET ADDRESS Route 32		
3. NAME OF DECEASED (Type or print) Phyllis Elizabeth Gosnell			4. DATE OF DEATH Month Day Year Nov. 9, 1966		
5. SEX Female 6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 1-31-1912 9. AGE (In years last birthday) 54 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Maryland		
13. FATHER'S NAME Edward Cavey			14. MOTHER'S MAIDEN NAME Priscilla Gourhart		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-42-004 17. INFORMANT Mr. Eugene Gosnell Address Sykesville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			INTERVAL BETWEEN ONSET AND DEATH 5 - 10 min.		
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			CEREBRAL HEMORRHAGE		
DUE TO (b)			HYPERTENSIVE CARDIOVASCULAR DISEASE		
DUE TO (c)			2+ yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>			20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1935 20f. (City or town) (County) (State)		
21. I certify that (I) Wm. H. Lawson, Jr., M.D. attended the deceased from 1935 , 19, to 9 Nov 66 , 19, that (I) last saw the deceased alive on 9 Nov 66 , 19, and that death occurred at 11 P.M. from the causes and on the date stated above.			22d. DATE SIGNED 9/Nov/66		
22a. SIGNATURE 			22d. ADDRESS Box 54, RD #2, Sykesville, Maryland		
22c. PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M. D.			23d. LOCATION (City, town or county) (State) Howard Co. Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23d. DATE THEREOF 11-12-66 23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR ADDRESS Harry W. Haight Sykesville, Md.			25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE NOV 15 1966 Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1000

TO **Hospital** OR ATTENDING **Physician**: The law requires that the death certificate be executed within 24 hours after death.

11 **FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15742

15745

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Jessup		c. LENGTH OF STAY IN 1b 11 yr 11 mon.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxford	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Patuxent Institution		d. STREET ADDRESS Box 52, South Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle M.	Last Haddaway	4. DATE OF DEATH November 22 1966	Month Day Year
5. SEX male	6. COLOR OR RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-12	9. AGE (in years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) caretaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Oxford, Talbot Co. Md.	
13. FATHER'S NAME Julius Haddaway		14. MOTHER'S MAIDEN NAME Lillian Hill		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes 6/41 to 11/45		16. SOCIAL SECURITY NO. unkn.		17. INFORMANT Mrs. Norman Grimes, 1159 Sargent St., Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Pulmonary Embolism 5 minutes			
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Atrial Fibrillation			
DUE TO cause (a), stating the underlying cause last. (c)		Arteriosclerotic Cardiovascular Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)	20f. (City or town) 8-4-66	(County) (State)
21. I certify that (I) <input type="checkbox"/> attended the deceased from November 22 1966 , and that death occurred at 4:50 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 11-22-66			
22a. SIGNATURE Domingo C. Sorongon		22d. ADDRESS Patuxent Institution, Jessup, Md.			
22c. PHYSICIAN'S NAME (Type) Domingo C. Sorongon, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	23d. LOCATION (City, town or county) Oxford, Maryland (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/26/1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Oxford Cemetery	25b. REC'D BY REGISTRAR NOV 25 1966	
24. FUNERAL DIRECTOR MAURICE E. NEWNAM & SON, Easton, Md.		ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	
		DATE			

2721

1 M
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with \$10. PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15743

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15746

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Dayton		c. LENGTH OF STAY IN 1b lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Dayton		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Howard Road		e. STREET ADDRESS Howard Road		f. DATE OF DEATH Nov 5 1966		g. Month Day Year			
3. NAME OF DECEASED (Type or print)	First Fenton	Middle Cefus	Last Johnson	4. DATE OF DEATH Nov 5 1966	Month Nov	Day 5	Year 1966		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-89	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Algernon Johnson		14. MOTHER'S MAIDEN NAME Mary Elizabeth Grimsley							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-32-3514		17. INFORMANT Mrs. Leola Johnson Same as #2		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		Acute cardiac failure		INTERVAL BETWEEN ONSET AND DEATH instant.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Coronary thrombosis		instant.					
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and In my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Charles S. Whitaker, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 11-6-66	
EXAMINER'S NAME (Type) Charles S. Whitaker, M.D.		Address (Street, city, town, or county) Howard		23d. LOCATION (City, town or county) (State)		23e. REC'D BY REGISTRAR Jennings Chapel Howard Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-9-66		23c. NAME OF CEMETERY OR CREMATORIUM Jennings Chapel		25a. ADDRESS		25b. DATE NOV 10 1966	
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.									

2019

2020

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

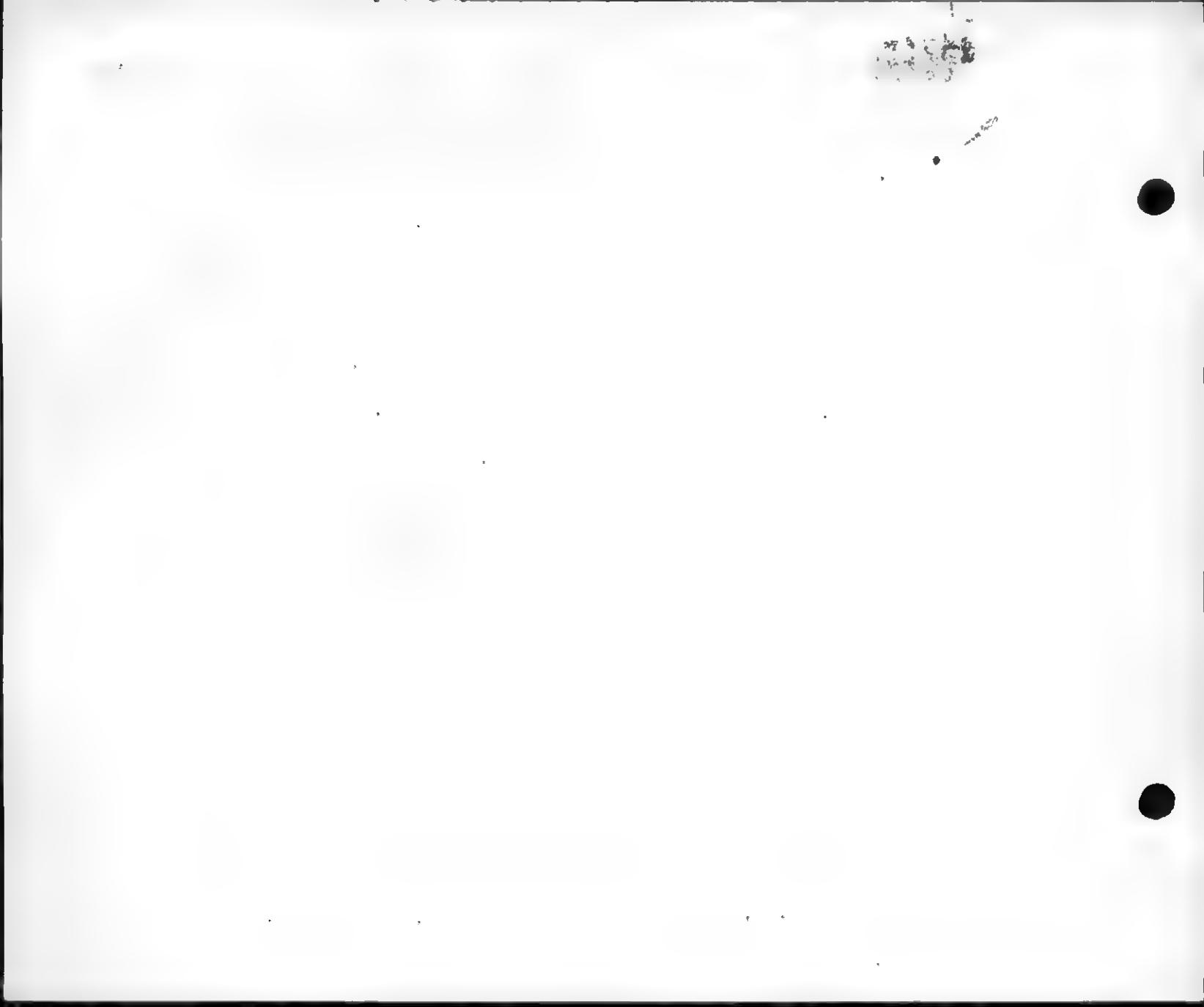
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15744

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15747

1 PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) One Spot		c. LENGTH OF STAY IN lb Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Rte. 1, S. of 175		e. STREET ADDRESS Box 255, Cedar Avenue	
3. NAME OF DECEASED (Type or print) HEZEKIAH		4. DATE OF DEATH November 16 1966 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED W DOWED	8. NEVER MARRIED DIVORCED
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinery Operator		B. DATE OF BIRTH March 13, 1913	
10b KIND OF BUSINESS OR INDUSTRY Sand & Gravel Co.		9 AGE (In years last birthday) 54 yrs	
13 FATHER'S NAME James F. Kennedy		11 BIRTHPLACE (State or foreign country) Augusta Co., Virginia	
14 MOTHER'S MAIDEN NAME Lucy F. Colvin		12 CITIZEN OF WHAT COUNTRY? USA	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 723-18-7869	
17 INFORMANT Mrs. Rose Kennedy, Same as #2		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries. 812.4 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pedestrian struck by auto.	
20c TIME OF INJURY Month, Day, Year Hour 3:30 11/16 1966 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) Street
		20f (City or town) One Spot	(County) (State) Howard Md.
21. I certify that I took charge of the remains described above, had an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
ACTUAL SIGNATURE <i>Charles S. Petty</i>	MD	22. DATE SIGNED 11/17/66	
EXAMINER'S NAME (Type) Charles S. Petty			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF Nov. 20, 1966	23c NAME OF CEMETERY OR CREMATORIUM Bell Valley Cemetery,	23d LOCATION (City or Town) Goshen, Virginia
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland	ADDRESS Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland	25a REC'D. BY REGISTRAR NOV 28 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

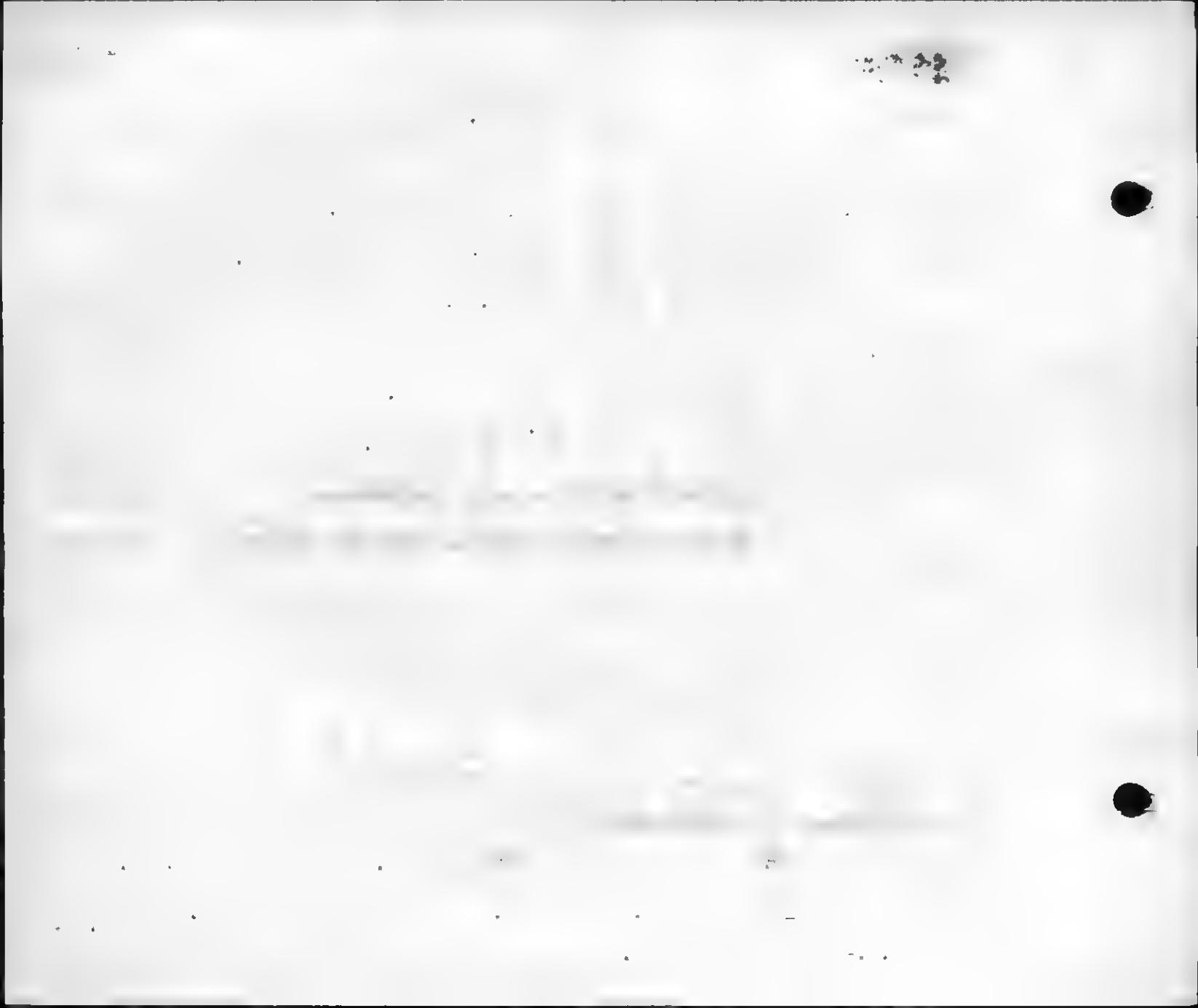
15748

CERTIFICATE OF DEATH

Reg. Dist. No.

15748

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 522 Edgewood St.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Schaeffer Conv. Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Maria		First	Middle	Last	4. DATE OF DEATH Nov. 18	Month	Day	Year			
S. SEX F	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1885		9. AGE (In years last birthday) yrs. 81	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Ridolfi		14. MOTHER'S MAIDEN NAME Unk.				Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Mr. Mario Maggenti 1910 Brookdale Rd.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
<i>Cerebral vascular occlusion</i> <i>Atherosclerotic cardio-vascular disease</i>										<i>10 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1-10, 1966		(County) 11-18, 1966		(State) 11-18, 1966	
21. I certify that I attended the deceased from 1-10, 1966 to 11-18, 1966 , that I last saw the deceased alive on 11-18, 1966 , and that death occurred at 5:35 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Thomas J. Herbert M.D.										ADDRESS (Street, city or town, state) 44 Church Rd. - Ellicott City, Md.	DATE SIGNED 11-19-66
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-66		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Bethesda, Washington, D.C.		(State) D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. - 4101 Edmondson Ave.		ADDRESS		24a. REC'D BY REGISTRAR NOV 22 1966		24b. REGISTRAR'S SIGNATURE Charles Judge		DATE			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15746

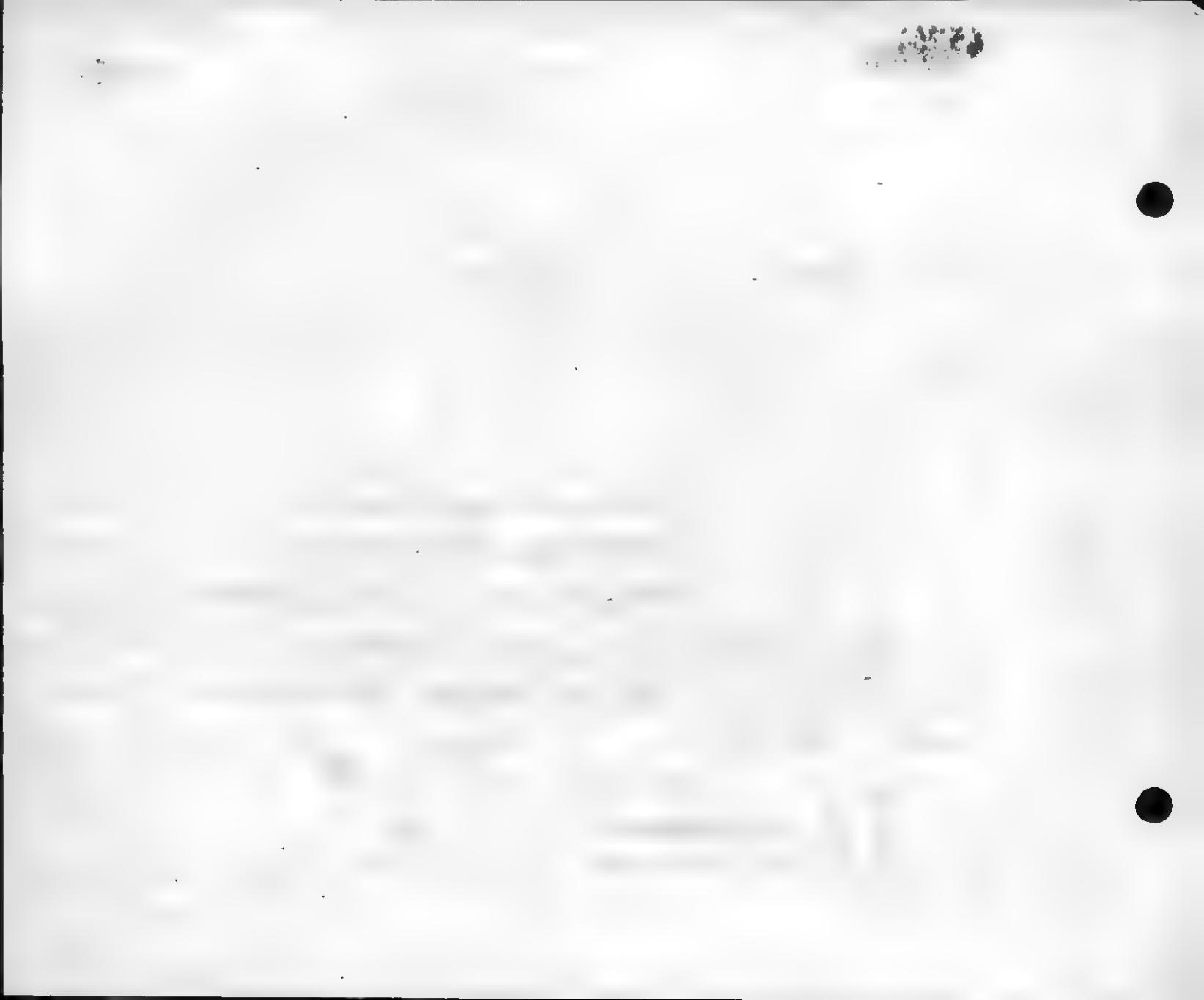
15749

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Hanover</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limts, write RURA and give nearest town) <i>Simpsonville</i>	c LENGTH OF STAY IN TB <i>114 Hunting Lane</i>	c CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) b. COUNTY <i>Simpsonville 151 Hanover</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>114 Hunting Lane</i>	d. STREET ADDRESS <i>114 Hunting Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>First CARA 120KA</i>	4. DATE OF DEATH Month Day Year <i>Mar 11 1966</i>	5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	
7. MARRIED W-DOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>April 7 1901</i>	9. AGE (In years at birthday) <i>65 yrs</i>	10. UNDER 1 YEAR Months Days Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life even if retired) <i>superintendent</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Women's Brian Hagerstown Md.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Hagerstown Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Wilbur Baechtel</i>	14. MOTHER'S MAIDEN NAME <i>Edna Semler</i>	Address <i>Mrs Gilbert Athey</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>4046</i>	17. INFORMANT <i>Mrs Gilbert Athey</i>	18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>Pulmonary Embolism</i> <i>Thrombo Phlebitis</i> <i>Fractured Fibula Head.</i>	19. INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
20a. ACCIDENT WAS UNDER YING OR CONTRIBUTING CAUSE OF DEATH (If either notify MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell at home and injured Rt. knee.</i>	20c. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20d. TIME OF INJURY Month, Day, Year Hour am <i>10/17 1966</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Jessup How. Md.</i>		
21. I certify that (I) (this hospital) attended the deceased from <i>10/17/66</i> to <i>11/11/66</i> , that (II) (we) last saw the deceased alive on <i>10/11/66</i> , and that death occurred at <i>5 P.M.</i> from causes and on the date stated above	22a. SIGNATURE <i>J M Warren</i>			
22b. DATE SIGNED <i>11/11/66</i>	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>Laurel 86 Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11/14/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St Marys Cem Laurel</i>	23d. LOCATION (City or Town) (County) (State) <i>Laurel Pg Md.</i>	
24. FUNERAL DIRECTOR <i>Mr. Wilt Daniels Laurel Md.</i>	ADDRESS <i>Laurel</i>	25a. REC'D BY REGISTRAR DATE NOV 15 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

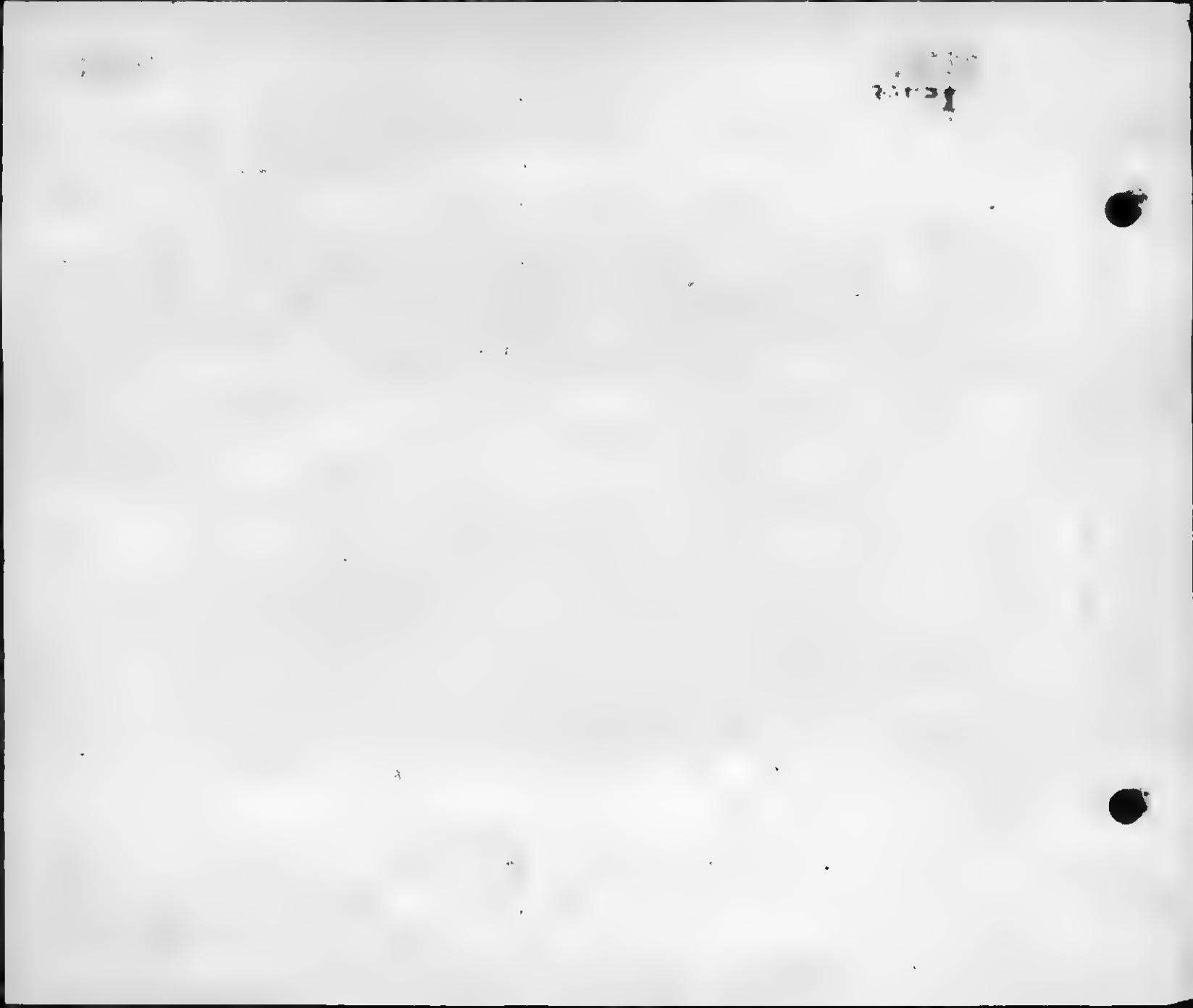
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15767

15751

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hammond Village		b. COUNTY Howard	
c. LENGTH OF STAY IN TB 1 YR + 1 MO.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hammond Village	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2906 German Rd (LAUREL)		d. STREET ADDRESS 2906 German Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helene	First m.	Middle Schmid	4. DATE OF DEATH Month Nov
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 15 - 1924
9. AGE (in years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 217-14-2184	
11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Skrupski		14. MOTHER'S MAIDEN NAME Josephine Jarkiewicz Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) No		16. SOCIAL SECURITY NO. 217-14-2184	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2140 Sandy Spring Rd, Buntontown Md.
20f. (City or town)	(County)	(State)	22b. DATE SIGNED 11-27-1966
21. I certify that (I) (this hospital) attended the deceased from 11-5 , 19 66 to 11-27 , 19 66 that (I) (we) last saw the deceased alive on 11-24 , 19 66 and that death occurred 2140 Sandy Spring Rd, Buntontown Md. from the causes and on the date stated above.		22c. SIGNATURE Milton H. Witke	
22e. PHYSICIAN'S NAME (Type) Milton H. Witke, M.D.	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 4140 Sandy Spring Rd, Buntontown Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/30/66	23c. NAME OF CEMETERY OR CREMATORIAL MEADOWRIIDGE	23d. LOCATION (City, town or county) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witke	ADDRESS 321 Columbia Pike, Ellicott City Md.	25a. REGD. BY REGISTRATION NO. NOV 29 1966	25b. REGD. BY SIGNATURE Peter Judge
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by the attending physician's directress, page 3 should be detached for use as the burial-transit permit. Then place a removable carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

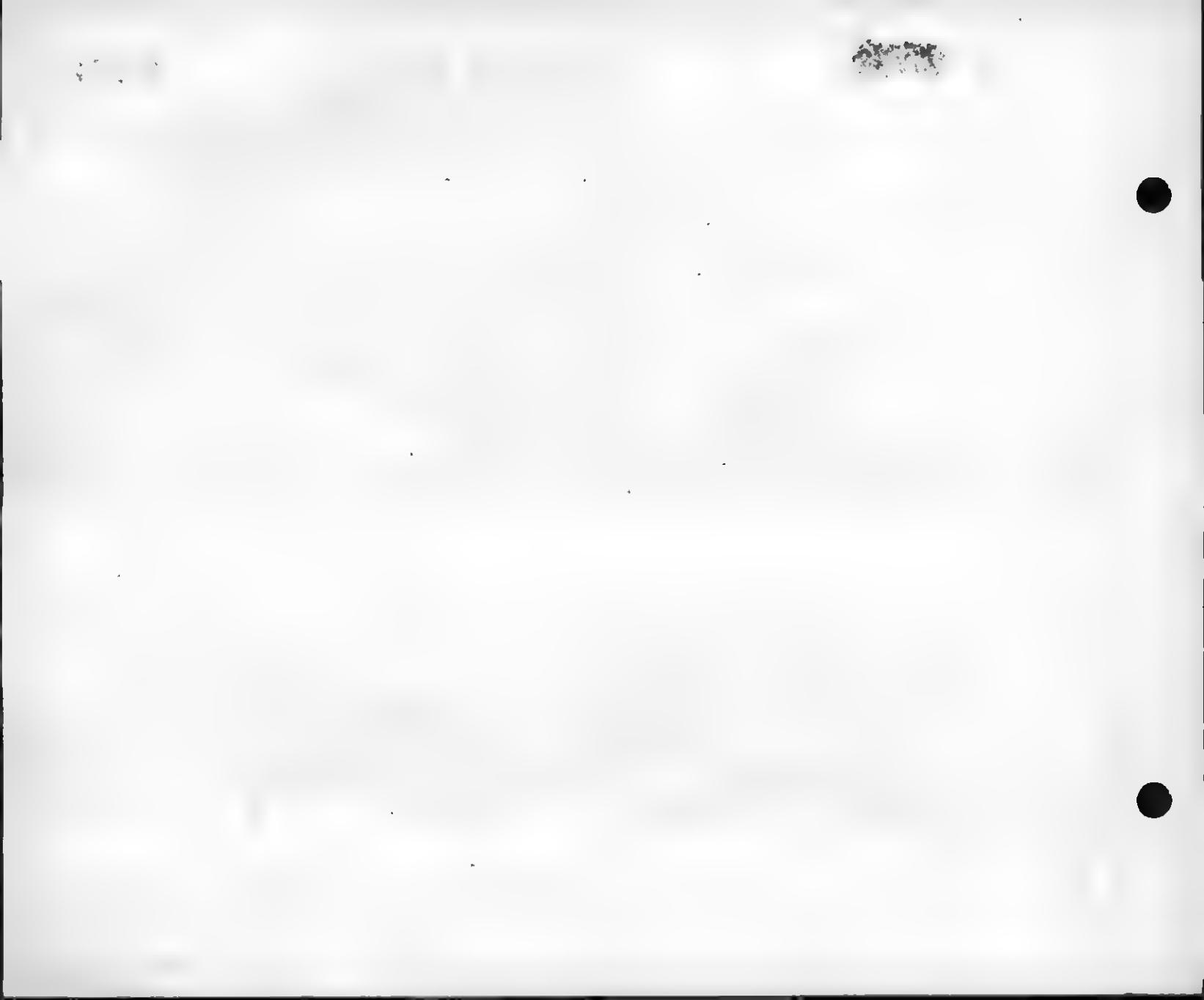
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15748

CERTIFICATE OF DEATH

15751

1 PLACE OF DEATH a. COUNTY Howard			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			b. COUNTY Baltimore		
c. LENGTH OF STAY IN 16 7 Mos.			c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shaeffers Retreat Conv. Home			d. STREET ADDRESS 3120 Rolling Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) Ethel V. Smink		First	Middle	4 DATE OF DEATH November 3 1966	Month Day Year
5 SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-9-1875	9 AGE (In years lost birthday) 91 yrs
10a USUA. OCC.PAT ON (Give kind of work done during most of working life, even if retired) At Home		10b K ND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore County	
13. FATHER'S NAME Amos Widerman			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Francis C. Smink 3120 Rolling Road	
18. CAUSE OF DEATH (Enter only one cause per line) (a) PART - DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		"Coronary Insufficiency" "Arteriosclerotic Disease - CVAT" "Coronary Insufficiency"		INTERVAL BETWEEN ONSET AND DEATH 1 day 5 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (b) DUE TO (c) DUE TO		Arteriosclerotic disease - generalized		15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg, etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1950 , to Nov 3 1966 , that (I) (we) last saw the deceased alive on Nov 3 1966 , and that death occurred at 11:30 AM causes and on the date stated above.					
22c. PHYSICIAN'S NAME (Type) THOMAS E. WHEELER		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-4-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-7-66		23c. NAME OF CEMETERY OR CREMATORIUM Lorraine Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		23e. ADDRESS 4600 Liberty Hghts. Ave		25a. REC'D BY REGISTRAR DATE NOV 7 1966	
24. FUNERAL DIRECTOR Ellsworth Anwest		ADDRESS 4600 Liberty Hghts. Ave		25b. REGISTRAR'S SIGNATURE James J. ...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15749

CERTIFICATE OF DEATH

15752

1. PLACE OF DEATH a. COUNTY <i>Hanover</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Hanover</i>	
b. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town) <i>Jessup</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town) <i>Jessup</i>	d. STREET ADDRESS <i>Bay 454 Guilford Rd</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bay 454 Guilford Rd</i>		d. STREET ADDRESS <i>Bay 454 Guilford Rd</i>	
3. NAME OF DECEASED (Type or print)	First <i>Charles</i>	Middle <i>James</i>	Last <i>Taylor</i>
4. DATE OF DEATH	Month <i>November</i>	Day <i>29</i>	Year <i>1966</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>Aug 13 1889</i>
9. AGE (In years last birthday) <i>77 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WARPER</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Cotton mill</i>	12. BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i>
13. FATHER'S NAME <i>John Taylor</i>	14. MOTHER'S MAIDEN NAME <i>Mary Warren</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs Ozzella Taylor Jessup Md.</i>	18. INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			
21. I certify that (I) (this hospital) attended the deceased from <i>11/28</i> , 19 <i>66</i> , to <i>11/29</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>11/29</i> , 19 <i>66</i> , and that death occurred at <i>29</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>J M Warren</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>J M Warren</i>		22d. ADDRESS <i>LAUREL Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/2/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Meadowridge Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Hanover Md.</i>
24. FUNERAL DIRECTOR <i>De Witt Funeral Home Laurel Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>DEC 3 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
16750				15753									
1. PLACE OF DEATH a. COUNTY Howard				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b				b. COUNTY Howard					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 338 Columbia Pike								c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City					
d. STREET ADDRESS 338 Columbia Pike								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First MAY		Middle ELIZABETH		Last TITSWORTH		4. DATE OF DEATH Nov. 12, 1966		Month Day Year 19 19 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 2, 1897		9. AGE (in years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Ellicott City, Md		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Crawford Moxley				14. MOTHER'S MAIDEN NAME Mary Etta Elizabeth Webb				Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. ?		17. INFIRMITY Roger H. Tittsworth, Ellicott City, Md		INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO (b) CARCINOMATOSIS - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CARCINOMA, BREAST. DUE TO (b) 2 MO. OUE TO (c) 4 MO.									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus.									
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to 11-12, 19____ that (I) (we) last saw the deceased alive on 11-9 19____, and that death occurred at 12 th p.m. from the causes and on the date stated above.		22a. SIGNATURE <i>John H. Higginbotham</i>											
22c. PHYSICIAN'S NAME (Type) F.C. Higginbotham, Ellicott City, Md.		22d. ADDRESS 401 Ellicott City Rd											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-15-1966		23c. NAME OF CEMETERY OR CREMATORIAL St. Johns		23d. LOCATION (City, town or county) Ellicott City, Md		(State)					
24. FUNERAL DIRECTOR F.C. Higginbotham, Ellicott City, Md.		25a. REC'D BY REGISTRAR NOV 14 1966										25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE													

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methylated

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Fertilizer - 100% methylated 10%

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